PREPARED STATEMENT

OF

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SUBCOMMITTEES ON MILITARY PERSONNEL AND READINESS

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Madam Chairwoman, Mr. Chairman, good afternoon and thank you for the opportunity to share with you the some of the progress we have made to improve our medical facilities within the Department of Defense (DoD).

I am pleased to be joined today by the Surgeons General and Peter Potochney representing Mr. Wayne Arny, each of whom has shared their commitment to improving the quality of our built environments – whether they be hospitals, clinics, training centers, research laboratories, or mission support facilities.

Lieutenant General Schoomaker, Lieutenant General Roudebush, and Vice Admiral Robinson and I are all physicians. Together we have many years of experience in caring for patients, sometimes in the finest facilities in the world, and at other times in a tent in a war zone or ship at sea. Some of us have been patients, too, and we know what it feels like to lie in a hospital bed with an uncertain future. And we all experienced the satisfaction of sharing good news with a patient's family, and the sadness we feel when the news is not so good. Having spent so much time in health care facilities, we all recognize their contribution to the delivery of care.

Our buildings can enable or impede the work that occurs within their walls. They can be institutional in appearance, inefficient in size or configuration, and not able to readily adapt to constantly evolving technology, clinical practices, and patient expectations. Or they can be safe, efficient, and welcoming – providing the environment that conveys the message to our patients, their families, and our staff, that we understand their needs and will do everything possible to meet them.

My goal today is to apprise the members of this committee of our approach to creating the facility infrastructure of which we can all be proud. I hope to achieve this goal by providing you with a clear understanding of how the DoD and the Services collaborate to overcome the many challenges we face in our efforts to acquire and operate our medical facilities. You will learn of the transformational changes we have made to improve our capital investment decision-making and gain some insight as to its positive impact on our future. And I sincerely hope you will leave today knowing that there are many motivated, capable people -- in the DoD, the Army, the Navy, and the Air Force -- striving together to

acquire and apply the knowledge and best practices necessary to make our buildings the very best we know how.

The Current State of Medical Facilities in the DoD

The DoD acquires, maintains, and operates a unique collection of medical facilities around the globe. By any standard, this facility inventory could be described as large, complex, diverse, and aging. The current inventory consists of over 1,000 major facilities and includes:

- 59 hospitals
- 663 medical and dental clinics
- 258 veterinary clinics
- 26 medical research and development facilities
- 19 training facilities
- 10 medical installations

The majority of military medical facilities are well-maintained from a facilities standpoint, Recapitalization of this large and diverse set of complex buildings poses substantial challenges. About 41% of our inpatient facilities are over forty years old and 72% were constructed more than twenty years ago. Most of our hospitals were constructed prior to the introduction of modern and ever-changing clinical processes and technology that today are considered the standard of care.

The Importance of DoD Medical Facilities

I believe our medical facilities are a strategic national asset. Our buildings support the vital, diverse, and worldwide mission of the Military Health System (MHS). We need outstanding facilities to deliver patient care, train medical professionals, conduct cutting edge research, and provide the support functions necessary to succeed on the battlefield and protect our nation.

Health Affairs as Facility Advocate

Let me be clear that, in my role as the Assistant Secretary of Defense for Health Affairs, I am a strong advocate not only for military medicine and the people who make it succeed, I am also a committed to dramatically improving our facilities. I take this responsibility seriously and have worked with the Surgeons General and others in the DoD to raise our own bar and ensure my conviction that high quality facilities are essential to the success of our Armed Forces and the security of our nation.

There are many others in the Department that share my perspective. You may recall that, in May of 2007, Secretary Gates stated, *"Our nation is truly blessed that so many talented and patriotic young people have stepped forward to serve. They deserve the very best facilities and care to recuperate from their injuries and ample assistance to navigate the next step in their lives, and that is what we intend to give them. Apart from the war itself, this Department and I have no higher priority."*

We provide life-saving services to both the toughest war fighter and the most vulnerable newborn. The work we perform in our facilities affects the readiness of our forces, the well-being of their families, and their willingness to continue serving our nation. Our facilities represent the tangible commitment we make to our active duty service members and their families. Investing in our buildings tells people that we care about them. Where our facilities fall short, we send a signal that taking care of our people is not a high priority.

Health care is one of the few functions performed within the DoD that can be compared directly to our civilian counterparts. We must compete with the private sector for the loyalty of our patients. The perceived quality of our facilities can often influence the perception of the quality of care we deliver. In those instances where these perceptions have not been favorable, patients and families have demonstrated a willingness to seek other options for their care. In order for the MHS to succeed, we need a diverse and robust

mix of patients coming through our doors to train and maintain the readiness of our medical staff and our deployable medical capability.

Modern hospitals are expensive and complex environments where information systems, cutting-edge equipment, and trained staff converge with the basic human needs, fears, and hopes of our patients and their families. We operate hospitals 24 hours a day, every day, and in so doing continuously consume millions of dollars in supplies and pharmaceuticals, feed thousands, park hundreds, run utility plants and laundries, process the deceased, comfort and provide a place for spiritual healing for families, while treating hundreds of thousands of patients, including our war wounded. We are subject to inspection and accreditation by outside entities and must meet their standards in order to continue operations. Our facilities are among few others in the DoD subject to outside civilian review to confirm their accreditation in striving for world-class health care. Allow me to take a moment to express my appreciation for the Congress and your efforts to provide focus on our facilities. As one recent example, the engagement of Defense Health Board and their independent design review of the National Capital Region Base Realignment and Closure (BRAC) projects. I welcome their soon to be published assessment and recommendations, which we expect to receive this month. We are certain they will confirm our investment strategy, and provide guidance for further improvements we intend to make to improve service and care.

As we learn more about the impact of the built environment on human performance, we find ways to balance the provision of care that combines “high tech” with “high touch”. I can assure you that my experience on both sides of the patient bed has confirmed for me the absolute necessity to design and operate our facilities in ways that fully support the human needs of our patients, their families, and our medical professionals.

The potential also exists for adversaries to unleash chemical or biological weapons on distant battlefields as well as on our own soil. As part of our mission, the MHS must also address the national security imperative to replace unique but costly, biological, and chemical research facilities. DoD is committed to conducting the advanced research necessary to counter such threats. The Department has recognized the need to construct the

facilities necessary to better understand these dangerous agents and develop preventive and therapeutic interventions. Currently underway are replacements for the U.S. Army Medical Research Institute of Infectious Diseases at Fort Detrick, MD, and the U.S. Army Medical Institute of Chemical Defense, located at the Aberdeen Proving Grounds, MD. These two facilities represent an investment in excess of $1 billion. Neither facility may ever treat a patient, but the work performed there may save countless lives of combatants and civilians.

Finally, our buildings typically cost more to design, construct, and operate than other facilities within the DoD inventory and must be resourced to keep pace with the increasingly dynamic world in which military medicine operates today and in the future. Just as we have a responsibility to care for our people, we also must serve as stewards of the resources provided by the American taxpayer. We must provide and operate truly excellent facilities but do so in a fiscally responsible manner. Striking this balance represents a significant challenge, but one I am confident we can meet especially if we all take an advocate and stewardship role.

Given the importance, cost, and complexity of our medical facilities, it is essential to strive for the knowledge and best practices and apply them to our buildings. We must also obtain the resources necessary to ensure we acquire and maintain the right mix of modern hospitals, clinics, research laboratories, training centers, and support facilities as platforms for the multiple missions of the MHS. Before addressing the actions we have taken in recent years to improve our infrastructure, I would like to provide some context that hopefully will help you understand the extent of our efforts to improve this vital national asset.

Historical Perspective for Facility Management in the MHS

Consolidation within the DoD of the three Service medical military construction programs followed the 1986 report of the *DoD Blue Ribbon Panel on Sizing of Military Medical Facilities.*

I think it is safe to say that prior to 1986, each of the Service medical departments did the best job possible in competing for resources from the line for their respective medical facilities. They faced stiff competition from their line counterparts, who also required buildings, weapons systems and other support directly tied to war fighting. This lack of support for medical facilities over the years was coupled with the lack of a coordinated approach to planning, design, construction, and maintenance and prohibited the MHS to deliver a uniform and consistent health benefit.

The Blue Ribbon Panel assessed the processes by which the Army, Navy, and Air Force each planned, programmed, and acquired their medical facilities. Among their findings, the panel noted an absence of:

- consistent cost models
- cost estimating standards
- common planning assumptions
- consistent functional and design criteria
- a coherent method to define priorities and select projects for funding
- central process and inventory management
- centralized advocacy

The findings and recommendations of the Blue Ribbon Panel led directly to the creation in 1987 of a central function to manage and coordinate the planning, programming, and acquisition of military medical facilities. Established under the Assistant Secretary of Defense (Health Affairs), this office has undergone organizational evolution over the years and is now organized as the Portfolio Planning and Management Division (PPMD) in TRICARE Management Activity (TMA). The staff of PPMD works closely with the respective facility offices in the Army, Navy, and the Air Force and coordinates with the other key stakeholders from within and outside the Department on all matters pertaining to health facility life-cycle management including planning, programming, funding, and acquisition. PPMD supports me in my capacity as the advocate and resourcer for the entire medical military facilities portfolio.

Since the consolidation occurred in 1987, most of the deficiencies reported by the Blue Ribbon Panel have been addressed and the medical military construction program has become more robust. But as the active duty forces were reduced following the end of the Cold War, the resources made available to acquire and renew our medical infrastructure were not sufficient to keep pace with demand, changes in codes and practice, new technologies, and modern health care environments.

Eventually the process by which resources were allocated to the needs of each Service became one based on the size of their respective existing inventory. Available funding was allocated to each of the Service medical departments based upon the percentage of the total inventory attributed to their respective Service. While this approach essentially guaranteed the Army, Navy, and Air Force medical departments with a predictable funding stream, it came with some significant drawbacks. For one, the relative small increases in medical military construction funding could not keep pace with rapid cost growth for building supplies, labor, and equipment. Each year, the Services were forced to put forward the proposed projects they could afford and not necessarily those that were their most compelling. A form of "horse-trading" sometimes took place, where one Service might donate a portion of its allocated share to another with the expectation that it would be repaid in the future. The net effect was that our hospitals began to grow older, become less efficient, and lose their appeal to our patients and their families. The previous allocation method also prevented us from linking our capital investments to a more systematic, MHS-wide business model.

A study conducted for the Department in 2003 compared private sector health systems with DoD. The results showed that private and public hospitals recapitalize their inventory approximately every 21 years – a benchmark rate that we, at over 50 years, were not close to meeting. This study helped confirm our assumptions – that each year we were falling further behind in efficiency, appeal, and core capability of our medical facilities.

Bright spots have emerged since that study in 2003 was completed. The commitment of the Department and Congress to successful implementation of the 2005 BRAC recommendations has helped us take a major step forward. Recapitalization of the

major facilities in two of our largest markets would not have been possible without this Department level commitment and investment. Other resources made available through the Fiscal Year (FY) 2008 Defense Supplemental Appropriations Act and generated by actions to grow the Army and Marine Corps to re-station forces from overseas have also contributed to our bottom line.

As part of the Defense Health Program, the Department programs and budgets Medical Military Construction projects as part of the Defense-wide Military Construction account. The requirements for medical projects are identified by the Military Service operational and medical communities and submitted to Health Affairs (via TMA), which reviews the projects and facilitates determining priorities in coordination with the Military Departments. The prioritized projects are then vetted through the Department's program and budgeting system where civilian and line leader/stakeholders advise the final decisions that inform the Department's presidential budget submitted to congress. Other strategic initiatives such as grow the force and BRAC influence this decision process by helping inform the prioritization scheme. The entire OSD leadership team (Comptroller, Health Affairs, Program Analysis and Evaluation, Installations and Environment) provide oversight throughout the process. For the FY 2010 President's budget and the FY 2010 to FY 2015 Future Years Defense Program, the Department instituted a new medical enterprise-wide approach and decision support tool to help prioritize the projects. The collective effort of the new prioritization method and Military Department efforts associated with grow the force have all been factored into the development of the FY 2010 budget as DoD prepares to execute our medical capital improvement program.

Concurrent with the growing awareness that our medical facilities were not receiving the resources necessary, we engaged experts in each Service to identify a methodology that would resolve a lingering problem first identified by the Blue Ribbon Panel in 1986 – the absence of a rational and fair process to prioritize the competing requirements of the Army, Navy, and Air Force for medical military construction funding. As a leadership team, we needed an approach that could:

- balance the needs of an integrated health system while respecting the unique operational requirements of each Service
- rationally determine why one proposed investment might be more important than another
- help ensure that our capital investments align with the strategic imperatives of the Department and the MHS
- help articulate our requirements for the resources necessary to provide a modern, capable medical facilities infrastructure

To address this requirement, we embarked on a process which led to development of our Capital Investment Decision Model (CIDM). I would now like to share with you some of the details about the process and model and how its implementation has improved transparency, management and oversight.

The MHS Capital Investment Decision Model

In 2005, we first looked to assess the state of the art in decision-making, with the expectation of adapting best practices we found for use in the MHS. Our research took us to our colleagues at VA who have employed a structured decision-making process since 1997. The VA shared their insights and lessons learned which we applied to the design of our process.

Together with representatives from each of the Services, our collective staffs developed evaluation criteria and establish the business rules that would govern implementation of the CIDM. We proceeded in a deliberately sought consensus among the Service medical departments. We recognized from the outset that developing and implementing the CIDM represented a change from status quo. Moving to this new approach also had an impact on our planning, design and construction partners, the Naval Facilities Engineering Command, the U.S. Army Corps of Engineers, and support teams responsible for performing project planning. Transitioning to CIDM was essential to our

efforts to systematically improve our facility inventory and by extension life cycle management by improving the process that guides investment.

The CIDM work group agreed on the following investment evaluation criteria and their associated weights:

- **Strategic and Tactical Alignment 33%**

  How well does the proposed investment support near and long-term direction articulated by DoD and MHS senior leadership?

- **Risk Mitigation 33%**

  What are the risks of not supporting the proposed investment?

- **Physical Environment 22%**

  Does the proposed investment support provision of safe, compliant, contemporary environments that focus on the needs of our customers?

- **Operational Performance 12%**

  Will the proposed investment support improved utilization of resources?

Once consensus was reached concerning the criteria, each of the Services developed their capital proposals, using a mutually agreed-upon format and schedule. Each Capital Investment Proposal (CIP) was submitted online and consists of:

- a standard template describing the project and its relevance to the evaluation criteria
- a Form DD1391 that reflects scope and cost
- a summary program for design describing the type and quantity of space required
- a standardized net present value analysis of alternatives
- photographs of existing facility conditions and/or potential construction sites

The Services submitted a total of 43 CIPs (to a secure web site) in late May of 2008, reflecting their own highest priorities. A diverse panel of medical professionals from the Services, Health Affairs, and TMA, including physicians and administrators at the O-6 or GS-15 level, reviewed the CIPs. Each reviewer recorded his or her score (via the web) using a common decision support tool. The tool recorded all the scores and provided a strawman "order of merit" list for the 43 proposals. Together, the Surgeons General and I

reviewed this list of priorities as part of our Senior Medical Military Advisory Council responsibilities. This list of priority investments is the heart of our medical military investment plan for FY 2010 through 2015.

I look forward to sharing with you the details of the plan after the President submits his budget next month and more recently, the recent addition of military hospital projects as part of the American Recovery and Reinvestment Act of 2009. We remain grateful for your support in all of our investment programs.

It is worth noting some of the important features of our new decision-making process. First, each Service was asked to submit sufficient proposals that would drive them to a 21-year recapitalization rate consistent with the study conducted in 2003. We did not impose an artificial programming limit but instead asked for submissions to address their actual requirements. We believed it essential to develop not only which investments were the most compelling, but also identify the full array of resources necessary to address them, including initial outfitting and future operations and staffing costs.

Unlike the previous method for allocating resources, we attempted to link our capital investment strategy to the strategic imperatives of the MHS. Each potential investment would be viewed not just from the perspective of the acquisition cost, but also include consideration of facility life cycle costs. We fully appreciate that the total cost of facility ownership occurs in operating and maintaining buildings over several decades including the initial and important investment for design and construction.

While the software produced an order of merit listing but also provided the capability to adjust inputs, such as criteria weights or funding levels, and create alternative investment scenarios. The Surgeons General and I reviewed, debated, and ultimately approved our final priority list. We considered various options and in the end made adjustments where we deemed appropriate. This final version was shared appropriately with leadership and other key stakeholders in the Department. The program that the Surgeons General and I approved was subsequently validated through the Department's program review process without further adjustment.

Anticipating the Future

While pleased with our new decision-making process, we know it is far from perfect and needs to continually adapt to changing requirements. The outputs from our Capital Investment Decision process have helped build a rational foundation for building an investment program for our most urgent needs. The results also helped demonstrate the size of the fiscal challenge we face and how resources would be used if provided. The Surgeons, my staff, and I have used this information to internally adjust our proposed funding priorities for the future.

I must stress to you that we do not intend to build bigger, newer versions of our existing hospitals and clinics. The clinical process and technology changes we see emerging every day -- coupled with our growing understanding of the impact of health care facilities on safety, outcomes, and operational efficiencies – compel us to create environments capable of "leaning forward." We strive to be both "high tech" by incorporating the latest technical innovations in health care, and "high touch" by providing the environment and support needed by our most important asset – our active duty members, their families, and the dedicated professionals of the MHS.

We are also engaged with leaders in both the public and private sectors, along with academia, to share knowledge and pursue best practices. We continue to work with VA leaders, both to ensure the best care for our patients and the best facilities. Health Affairs has also engaged experts at Georgia Tech and Rice University to help us acquire knowledge, conduct collaborative facilities research, and improve our acquisition and business processes. The Army Medical Command works with Clemson University to investigate hospital room design and test new approaches in actual clinical settings. We have assumed a prominent position in the national community dedicated to creating safe and efficient healing environments. Our work has been highlighted in a variety of national publications, including national newspapers and professional journals. We have forged collaborative relationships with other health systems, including Kaiser-Permanente, the Mayo, and Cleveland Clinics. These research associations allow us to learn from the best

and to share with them some of our innovative system-wide approaches to the planning, acquisition, and operation of our facilities.

It is with great pleasure that I can report to you the genuine willingness of our colleagues outside the Department to work with us. We have also found that the MHS has a good story to tell and that we have a real capability to contribute to the delivery of better care in better health and research buildings across the nation.

My colleagues, the Surgeons General, are charged with operating the facilities, delivering care, conducting research and training activities, and directly supporting our soldiers, sailors, airmen, marines, their families, and others entrusted to our care. My job is to help my colleagues successfully conduct of their missions. I do that by advocating for and obtaining resources and working collaboratively to create the fiscal and business roadmap that will lead us to a future to which we all aspire.

I would like to conclude my time with you today by stating that we have made great progress in recent years and have a clear idea of where we must be in the future. Congress has played a supportive role in the concerted effort to improve the quality, capabilities, and effectiveness of our medical facilities. Most recently, inclusion of $1.33 billion for funding of military hospital construction in the American Recovery and Reinvestment Act of 2009 will help to provide the medical facility infrastructure so vital to our patients and their families. Our new MHS prioritization process was used to help determine which projects to fund.

Looking ahead, we are encouraged by the opportunity to continue to work with our partners in the VA as we pursue joint market and clinical solutions. We look forward to making our buildings greener as we take lessons from our facility research and apply them as new criteria for creating healthier healing environments. We also look forward to working with the Congress in the future to explore better, faster and cheaper ways to acquire and maintain our facilities as we leverage the talent in the private sector and use our investments as a way to stimulate the economy in both short- and long-term.

I appreciate the excellent support provided by the members of this committee, its professional staff, and others in Congress who share our passion to care for our nation's heroes and their families. It remains my humble honor to have served with you and to continue to work with you to improve the healing places for our heroes, current, past and future.

Thank you for your continued strong support of our military health care system and our infrastructure to support it.

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